MENTAL HEALTH AND DISABILITY SERVICES COMMISSION
July 17, 2014, 9:30 am to 3:00 pm
ChildServe Training Center
5406 Merle Hay Road, Johnston, IA
MEETING MINUTES

MHDS COMMISSION MEMBERS PRESENT:

Thomas Bouska
Thomas Broeker
Richard Crouch
Lynn Grobe
Kathryn Johnson
Betty King
Sharon Lambert
Geoffrey Lauer (by phone)
Brett McLain (by phone)
Michael Polich
Deb Schildroth
Patrick Schmitz
Marilyn Seemann

MHDS COMMISSION MEMBERS ABSENT:

Neil Broderick
Jill Davisson
Marsha Edgington
Senator Joni Ernst
Senator Jack Hatch
Representative Dave Heaton
Representative Lisa Heddens
Rebecca Peterson
Suzanne Watson

OTHER ATTENDEES:

Jess Benson	Legislative Services Agency
Teresa Bomhoff	Iowa Mental Health Planning Council/NAMI Greater DM
Kyle Carlson	Magellan Health Services of Iowa
Eileen Creager	Aging Resources of Central Iowa
Marissa Eyanson	Easter Seals
Connie Fanselow	MHDS, Community Services & Planning/CDD
Jim Friberg	Department of Inspections and Appeals
Zeke Furlong	House Legislative Staff
Mark Hanson	Iowa Association of Area Agencies on Aging (I4A)
Julie Jetter	MHDS, Community Services & Planning
June Klein	Brain Injury Alliance of Iowa
Jim Rixner	Siouxland Mental Health Center
Rick Shults	MHDS Division Administrator
Michelle Zuerlein	Alegent Creighton Health/Psychiatric Rehabilitation Assoc.

WELCOME AND CALL TO ORDER

Patrick Schmitz called the meeting to order at 9:40 a.m. and led introductions. Quorum was established with ten members present and two participating by phone. No conflicts of interest were identified for this meeting.

APPROVAL OF MINUTES

Richard Crouch made a motion to approve the minutes of the June 19, 2014 meeting as presented. Deb Schildroth seconded the motion. The motion passed unanimously. Betty King joined the meeting after the vote.

ADMINISTRATIVE RULES FOR DATA SUBMISSION TO DETERMINE MEDICAID OFFSET FOR COUNTIES

Rick Shults presented the rules package for data to be submitted to determine the Medicaid offset amount for counties. The Department is asking the Commission to notice these rules for publication and public comment; if approved for notice today, they will come back to the Commission again after that process for approval of final adoption.

In 2013, when the Iowa legislature passed the Iowa Health and Wellness Plan legislation, one of the provisions directed the Department to go through a process to identify savings that counties would experience because individuals who had not had Medicaid or other insurance coverage would qualify for IHAWP and it would provide coverage for the cost of services that were previously paid by county MHDS funds. This is known as the Medicaid offset or "claw back." The amount of the savings would be identified, and 20% of the savings would stay with regions. The other 80% of the savings (the offset) would come back to the state in two ways:

(1) If equalization funds (general funds) are available to the county, the county would return an equivalent amount of those funds to the State in January. Those funds would be set aside for the legislature to appropriate for mental health and disability regional services in a future legislative session.

(2) If the equalization funds were not sufficient to account for all of the savings, then in the subsequent year (in this case it would be SFY 2016), the county would reduce its mental health and disability services levy to cover the difference.

During the 2014 legislative session, there was debate about whether the offset provision should remain in the law, and, if so, how it should be calculated. The legislative choose to keep the provision, but the calculation was changed. The new calculation is based on a comparison of:

(1) the amount of county expenditures for a specific group of services for a specific group of people from July 1 through December 21, 2013 (the six months before IHAWP went into effect), and

(2) the amount of county expenditures for the same specific group of services for the same specific group of people from January 1, 2014 through June 30, 2014 (the first six months after the IHAWP went into effect).

The difference between the two amounts would be the savings attributed to the IHAWP.

The legislation also directs the Department to establish that amount and report it to the counties by October 15 of this year. The Department was also required to meet with the regional MHDS administrators and agree on the set of services and the population group to be used in the calculation.

The Department and the regional administrators met three times and they have agreed on the set of services using the uniform chart of account codes for counties and the method of identifying the group of people by diagnosis to form the basis of the calculation. The services are primarily mental health treatment services and inpatient psychiatric services and the diagnoses are primarily mental illness or chronic mental illness. DHS has also had a series of meetings with regional administrators to work out an agreement.

The legislation also authorizes the Department to established administrative rules. Since agreement was reached with the regions and the legislation is specific about how the calculation is made, only a minimal set of rules was needed. This rules package includes a few definitions, establishes the data required to be submitted to the Department, and the reporting time. Counties would be required to submit this data set by September 19, 2014, in the same manner that they ordinarily submit their data to the Department. There is also a provision that can be applied in case a county fails to submit data or if there is a problem with the accuracy of the data submitted. It allows an alternative methodology to be used.

Mike Polich asked if this is a one-time rule, noting the specificity of the dates. Rick responded that the rule does not sunset after the September 2014 date, but it was designed with this first year in mind and it may be necessary to modify or add to it in future years.

Sharon Lambert asked if notifying the counties mean notifying the CEOs? Rick responded county boards of supervisors and regional CEOs would be among the people who were notified.

Richard Crouch asked why this information is by county instead of by region. Rick responded that the data for this first year is from the period before the regions began operation. He added that there will need to be more conversation as this moves forward to sort out how the transition from counties to regions will be handled.

Deb Schildroth asked how the Department would apply a methodology using data submitted by other counties if a county fails to submit its data. Rick responded that DHS hopes they do not have to use that provision, but it would involve using aggregate data, not making comparisons to other individual counties or specific groups of counties. He said this county data is a subset of the information all counties submit every December, so it is not a new reporting system or different data than has been collected and reported in the past, so every county should have the information they need to report.

Patrick Schmitz asked for further clarification on how DHS would communicate with the counties. Rick responded that the legislation says the information will be communicated to the counties by the Department, and DHS will interpret that to mean communicating with supervisors, regional CEOs, and people who were serving as CPCs at the time the data was collected. He said the process will continue, with specific changes to the calculation after the first year and the rules will need to become more sophisticated moving forward.

The calculation method is specified in Iowa Code. This year we are comparing the first half of fiscal year 2014 with the second half of fiscal year 2014. In future years, we will compare a full fiscal year with the previous full fiscal year. Next year we would compare all of fiscal year 2014 with all of fiscal year 2015, and so on. The Code also provides for the Department and regional administrators getting back together to review the data set from time to time. The process is to continue as long as there are equalization payments going to the counties.

Motion & Vote – Richard Crouch made a motion to adopt the administrative rules for data to be submitted to determine the Medicaid offset amount for counties by filing the notice of intended action, pending approval of the Administrative Rules Review Committee (ARRC). Tom Bouska seconded the motion. The motion passed unanimously, with thirteen votes. Geoff Lauer and Brett McLain voted by phone.

Rick Shults noted that the rules will go to the ARRC for further approval, then will be published in the Iowa Administrative Bulletin for public comment, and will come back to the Commission after the public input process. To get the rules into effect before the reports are due, the Department will use the emergency after adoption process that waives the 35-day waiting period after public comment. That does not impact the public notice and comment period.

DHS/MHDS REPORT

Rick Shults presented an update on DHS and MHDS activities:

Regions – The MHDS regions began official operation on July 1. It was a smooth transition, but it continues to be an ongoing process. The regions will continue to refine their organization, develop their budgets, policies, and internal organization structures. Much of what the regions are doing now is what was envisioned by the redesign transition workgroup. Rick said that when he has talked with folks from other states, they are very impressed with how counties have come together to form regions.

DHS meets regularly with regional administrators and next week will also be meeting with the AAAs (Area Agencies on Aging) to talk about the process of working together on the ADRC (Aging and Disability Resource Centers), having single point of entry access, and how that can be supported at the state level. The single point of entry (also known as “no wrong door”) concept is the process by which a person can pick up the phone or walk through a door and be guided to find whatever it is they need.

Geoff Lauer expressed interest in making sure that the ADRC participants and regional administrator are aware of the Brain Injury resource facilitation services available statewide. Rick indicated that there are lots of services and groups of that kind that will need to be part of the discussion.

Rick was asked if the regional budget plans have been approved yet. He responded that the Department is currently going through certain steps to accomplish that. The plans are due August 1.

IHAWP – As of July 4, the overall enrollment was 106,511. Rick said that number speaks highly of the hard work of many people. Of that total, 83,113 were enrolled in the Iowa Wellness Plan, and 23,378 were enrolled in the Marketplace Choice Plan.

Jess Benson shared the most recently updated numbers:

- Total enrollment - 110,533
- Iowa Wellness Plan enrollment – 86,270
- Marketplace Choice Plan enrollment – 23,804
- Presumptively eligible - 459

Medically Exempt – As of July 4, 10,771 enrollees have been identified as medically exempt. Medically exempt individuals are those who are eligible for coverage under the IHAWP who can have their coverage assigned to the regular Medicaid plan because of a chronic health condition so they can access the level of services necessary to meet their needs. Mental illness is one of the chronic conditions that may qualify a person as medically exempt.

The process started with people self-identifying themselves and being referred by providers. The next step is to look at claims information under the plans identify people based on their diagnoses or the types of services they access. It takes some time to accumulate enough claims history to use for this purpose. Rick said the Department will continue to use self-identification, referral, and claims data to identify individuals who may qualify as medically exempt.

Integrated Health Homes – The last phase of the IHH rollout started July 1. We plan to have someone from Magellan come to the August Commission meeting to present more information on the process.

Deb Schildroth asked if a person who is enrolled in an IHH has a lapse in Medicaid coverage could continue to access the IHH. Kathy Johnson responded that that intent is to continue to help them get back on Medicaid, but IHHs would not be able to get reimbursed for that and sometimes people choose not to participate. Kathy added that this population includes a lot of people on MEPD (Medicaid for Employed Persons with Disabilities) and their coverage affects access to the IHH, medications, and other aspects of health care and sometimes people self-select not to participate. Jim Rixner agreed, saying that people move in and out of the system. He said those who move out, usually come back in sooner or later and his mental health center continues to work

with them to refer them to some level of service provision or other program. Kathy noted that one of the issues she has encountered is when a person has a lapse in eligibility at the time they are trying to get them enrolled in an integrated health home.

Kathy explained that MEPD is Social Security disability work incentive program that provides an opportunity for individuals to have earned income over the amount that would usually disqualify them from traditional Medicaid coverage and still be allowed to purchase their Medicaid coverage while they are working. There are currently about 16,300 people enrolled in MEPD in Iowa.

BIPP – Rick said that the Balancing Incentives Payment Program has had a significant role in redesign. In return for efforts shifting the balance of state funding toward community-based rather than facility-based services, the federal government has allowed states to receive 2% more in matching funds for specific types of Medicaid services. Last quarter, Iowa's balance was 52% community and 48% facility, which surpasses the 50/50 mark required. The state will need to maintain a balance in favor of community-based services. Rick said that the 2% funding increase has dramatically helped the state budget and the rebalancing effort is highly complementary to the Department's mission and vision. He clarified that the balance is about dollars spent, not about numbers of people served in facility or community settings. On an individual basis, the focus is on making sure people are getting services in settings that are appropriate to meet their needs.

Federal government policies define what is or is not community based. For example, a 4-bed Intermediate Care Facility for persons with Intellectual Disabilities (ICF/ID) is considered a facility-based setting and a Residential Care Facility (RCF) is considered a community-based setting. The determination is made by payment category.

Medicaid - Rick announced that Jennifer Vermeer, the Director of the Iowa Medicaid Enterprise (IME), will be leaving her position on August 21, after 9 years with Medicaid. She will be joining the University of Iowa Health Care as assistant vice president of medical affairs. Her work with the Department has been appreciated and she will be missed. Deputy Director Julie Lovelady will serve as the interim Director while a national search for Jennifer's successor is made.

Rick was asked where DHS is at in the process using the funding for the HCBS Waiver waiting lists. Rick responded that the Department is in the final phases of determining how the slots will be assigned and how the funding will be allocated.

Legislative & Policy Issues – The Department recently had its annual public meeting and Rick asked Teresa Bomhoff to share the information she presented at that meeting. Teresa shared a handout she developed listing non-monetary and monetary recommendations being discussed by advocacy groups as potential legislative priority items for the 2015 legislative session. They include:

"Non-Monetary (Policy) Recommendations"

- Establishing long term state funding for regional system (the $47.28 per capita rate expires June 30, 2016)
- Combining core and core plus services and mandating all service domains
- Requiring private insurance companies to cover all mental health core and core plus domains so that there are more payers supporting the system
- Mandating private insurance coverage for autism spectrum disorders and coverage for ABA (Applied Behavioral Analysis) without age limits
- Mandating private insurance companies to cover telehealth services
- Creating more incentives for expanding mental health workforce capacity
- Passing legislation to create a framework for children's mental health services
- Calling for a legislative study to make recommendations on changes to Iowa's HCBS Waivers
- Working with the Iowa Department of Education to provide mental health education to staff and students in schools and colleges
- Creating a refundable tax credit for home modifications to support individuals in remaining in their own homes
- Requiring 50% membership by persons with disabilities or family members in legislative workgroups and advisory groups
- Creation of an acute care bed tracking system
- A legislative study of financial support for community mental health centers
- Implementation of a court plan for mental health advocates
- Requiring re-credentialing of providers at one source for all payers
- Amending regional service and budget plan requirements to utilize a standard reporting form
- Issuing administrative rule on outcomes and performance measures for regions and providers
- Issuing administrative rules on "core plus" services
- Designating state Mental Health Institutes as the residence of last resort
- Updating the Olmstead Plan
- Implementing a 1 to 2 page standardized prior authorization form for use by all insurance companies
- Continuing outreach for the Iowa Health and Wellness Plan
- Speeding up approval of IHAWP medically exempt status
- Expanding the sports concussion law to cover youth of all ages in all organized sports
- Promoting alternatives to guardianship

"Monetary (Funding) Recommendations"

- Raising the $47.28 per capita levy rate for counties as needed to make services available throughout the State
- Using Medicaid offset funds for demonstration projects in the regions
- Establishing a reporting system and standardized codes to compare fees from all payers
- Ensuring adequate reimbursement rates for providers from all payers

- Providing additional funding for supporting mental health workforce and incentives for building additional capacity
- Funding to reduce the HCBS Waiver waiting lists
- Funding to train mental health education trainers
- Infrastructure funding for an acute care bed tracking system
- Funding for electronic health records for community mental health centers and the Iowa Behavioral Health Association
- Funding needed for implementing court plan for mental health advocates
- Adequate funding for Medicaid match and growth in the system
- Funding to increase MHI bed capacity
- Funding for navigators and/or certified application counselors to provide outreach for enrolling people in the IHAWP
- Funding needed to reduce wait time for medically exempt determinations

Teresa also noted that the refueling assistance bill, which was close to passing last year, is still a priority. It would require accessible call buttons at fuel pumps, and personnel to assist anyone who needs physical assistance in buying fuel.

OFFICE OF SUBSTITUTE DECISION MAKER

Paige Thorson, Legal Services Developer from the Office of Substitute Decision Maker, presented an overview of the re-established office, which is within the Iowa Department on Aging. Many adults in Iowa are not able to maintain their physical health or manage essential aspects of their financial resources and need substitute decision-making services.

Without a substitute decision maker, adults can be at risk of:
- Abuse and exploitation
- Medical or financial crisis
- Loss of their home or savings
- Being trapped in a costly and inappropriate level of care

The OSDM was originally started in Iowa in the late 1990s to create a statewide network of people who can provide substitute decision-making services as a last resort where no family member or other person is available to do so. At that time, a physician had concerns about serving people who lacked the capacity to make informed decisions. A task force was created, stakeholders were convened, and they identified a list of issues ranging from Powers of Attorney, guardianships, conservatorships, and a lack of people to serve in those capacities. They also proposed a list of solutions, with three priorities:

- Reforming financial Power of Attorney laws
- Statewide training for substitute decision makers to provide well-meaning people with the information and skills needed
- Establishing an Office of Substitute Decision Maker to provide public guardians, payees, and decision makers when needed

Legislation was drafted that became the Iowa Substitute Decision Maker Act (Iowa Code Chapter 231E). It established a State office and regional offices across the State that could recruit and train people who were willing to serve in situations where there was no one else willing and able to serve.

The OSDM can assist by:

- Advocating to protect people and ensure their safety
- Guard against people being financially exploited
- Offering training and education
- Providing consent needed to access to needed services
- Supplying alternatives to inappropriate or poor decision makers
- Helping to plan for incapacity

The Substitute Decision Maker Act became law in 2005 and first received funding in 2007. The initial amount of funding was $250,000, which was used to establish a statewide office, but was not enough to support regional offices. For two years, the office operated with an administrator, a legal assistant, and a part-time administrative staff person. They were able to intervene in those cases where a decision maker was acting inappropriately, provide training, and answer questions. Funding for the OSDM was eliminated in 2009 and, until recently, the law remained on the books, but there was not funding to operate the office.

This year the legislature appropriated $288,000 and the office was re-opened. The Department on Aging is planning to hire an administrator, legal assistance, and full time administrative assistant. The legal assistant serves as an intake person and resources in answering basic questions about substitute decision-making. A plan is being developed for making the OSDM as statewide program. Eventually additional funding will be needed to support people working out of regional offices.

Paige said they are working to demonstrate how important substitute decision-making services are so they will not lost funding again. People are encouraged to seek out the least restrictive alternative and rely on family or close friends for decision making when possible. The OSDM is needed for people who have no one else to step up and represent their interests. She encouraged others to sharing their support for the service with legislators.

Question: Is this service for older Iowans only, or also for people with disabilities?
Answer: Anyone over the age of 18 can be served. The office is housed in the Department on Aging and they were integral in drafting the legislation, but the OSDM can assist an adult of any age who needs their assistance.

Question: How does the office locate persons to serve as substitute decision makers?
Answer: An RFP (Request for Proposals) is expected to be issued. Local entities could apply to become regional offices and they would be responsible for finding and coordinating substitute decision makers in their area.

Question: Is there support in the legislature for continued funding?
Answer: Yes, there are legislators in both parties who understand the need and are willing to support continuation of the service.

Question: How many people have been served?
Answer: During the two years of operation from 2007 to 2009, there were about six interventions, which were in very time-consuming cases where the person was being inappropriately represented. There were also larger numbers of cases where resources were provided by the OSDM.

Paige shared handouts providing additional information about the Office of Substitute Decision Maker.

PUBLIC COMMENT

Jim Friberg commented that the administrative rules for sub-acute services have been out for public comment and will be going out one more time. The main issue at this point is whether it will be a voluntary program or not. Jim said they are close to being in final form and he anticipates that should happen by next month's meeting.

A break for lunch was taken at 11:25 a.m.

The meeting resumed at 12:30 p.m. The Commission members worked in two committee groups: regional services and cost increase recommendation.

COMMITTEE REPORTS

Cost Increase Committee – The cost increase group included: Tom Broeker, Betty King, Michael Polich, Patrick Schmitz, and Marilyn Seemann.

The committee formulated a two-part recommendation:

1. A percentage increase over the prior year's budget to address inflation, overall population growth based on most recent census data, and growth in service utilization. Using SAMHSA published cost increase and inflation factors for mental health services, the inflation factor would be a minimum of 1.5 to 2%.
2. An increase in funding to fully support the implementation of core services, and enable regions to add additional core plus services throughout the system, including expanding early intervention services and prevention services, that work to reduce the need for longer term and more intensive and costly services.

The committee will plan to present a draft of a cost increase recommendation letter to the full Commission in August for review. The recommendation needs to be submitted to the Director before September 1.

Regional Services Committee – The regional services group included: Tom Bouska, Richard Crouch, Lynn Grobe, Kathy Johnson, and Sharon Lambert.

The regional services committee is working to evaluate the status of services, and their availability and quality across the state. They reviewed reports and discussed how to use the available data in a meaningful way. They hope to be able to review the regional budget and service plans next month, learn more about what is available for persons covered by Medicaid, and further discuss how to more fully include services for persons with brain injury in the system. They would like to use this year's report as a baseline for future reports and want it to reflect the impact of the move from county-based to regionally-administered services as the new system is implemented.

The meeting was adjourned at 1:40 p.m.

Minutes respectfully submitted by Connie B. Fanselow.